even gold or silver. Currently, there are very few data in the literature about STIs and genital piercing but it has been postulated that there can be an increase in the risk of transmission of blood borne viruses as well as other STIs because of damage to condoms caused by these objects. A recent study[1] also did not find any association between body piercing and genital infections in general; however, we wondered whether genital piercing should be included in the KC 60 data collection. We would welcome observations from the readers of *STI* on this subject.

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1 Willmott FE. Body piercing: lifestyle indicator or fashion accessory? *Int J STD AIDS* 2001;**12**:358–60.

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Safer sex in HIV infected patients in London: practices and risks

EDITOR,—Recent figures from the Public Health Laboratory Service (PHLS) report[1] have shown the largest number ever of new cases of HIV infection (2868 cases) during 2000 in the United Kingdom. The majority of HIV infected individuals attending clinics for their treatment and care will have been counselled and strongly advised to practise safer sex. Specific risks of unsafe sex will be summarised, including the risk of transmission of HIV to their partners, as well as their own risk of acquiring new sexually transmitted infections, and the spectre of multidrug resistant HIV variants.

The overall effect of such safer sex messages were called into question by Dodds *et al*[2] who recently reported evidence of an increasing incidence of high risk sexual behaviour among homosexual men in London. The accompanying editorial by Grulich[3] called for improved data on risk behaviours, specifically in HIV infected individuals. We can present data on this from a questionnaire survey of patients attending the largest HIV outpatient centre in London.

The questionnaire was distributed to 500 consecutive individuals attending the Kobler HIV outpatient clinic at the Chelsea and Westminster Hospital during spring 2000. The confidential questionnaire could be completed anonymously if the patient wished. Data were gathered concerning the individuals' sexual behaviour over the past year in terms of number of sexual partners and episodes of unprotected sex. Further data were collected on whether individuals had sexually transmitted infections (STIs) diagnosed in the past year and/or attended for sexual health screening (table 1). We also asked them how they had acquired HIV infection.

A total of 494 legible questionnaires were suitable for analysis. Anonymous questionnaires were received from 240 respondents, whereas 254 (50.8%) disclosed their identity, and 35 (7%) were female. Although 317 patients (64%) reported engaging in only protected sex in the previous 12 months, 173 (35%) individuals had unprotected penetrative sex in the past year. This figure for HIV infected individuals has a remarkable concordance with the data for unprotected intercourse in a sample of homosexual men which reported a prevalence of 38%.[2] On further analysis of this group, it was revealed that a substantially higher proportion, 93 (54%), had unprotected sex with more than five partners, of which 40% had more than 10 sexual partners in the past 12 months.

Only 252 patients had a sexual health check up in the past year. There was a significant association between having a check up and reporting having unprotected sex. However, of those who had unprotected penetrative sex in the past year, 67 (39%) did not have a sexual health screen. A sexually transmitted infection had been diagnosed in 41% of respondents in the past year, which was significantly[4] associated with their increasing numbers of sexual partners.

We believe that major efforts to encourage sexual health check ups must be targeted to the key population of HIV infected individuals. The majority (76.2%) of our patients who had a sexual health check up in the last year, did so at the GU medicine clinic in the same building, contrary to the popular belief that HIV patients do not use local services for sexual health check ups.

Oral sex causing HIV transmission is biologically plausible though it is considered a less risky activity compared with unprotected vaginal and anal intercourse[5]. However, the frequency of its occurrence may serve to increase its relative contribution to overall HIV transmission. Inflammation or ulceration of the oral mucosa due to mouth ulcers, gingivitis, periodontal disease, pharyngitis, bleeding gums after tooth brushing or flossing could potentially lead to the increased risk of HIV transmission.

Six per cent of our studied population believed they acquired HIV infection through unprotected oral intercourse only. On reviewing the notes of the identifiable patients we concluded that five out of these 15 patients had no other risk factor other than unprotected oral sex recorded at any time during their counselling or management records, which can account for their HIV transmission. The remaining 10 patients' notes did not have enough evidence to support their claim that they acquired HIV disease through oral sex only. Three out of five of these patients had never engaged in anal sex and the remaining two always used protection.

Following this observation we have further identified six patients who have probably acquired HIV through unprotected oral sex, and we can summarise data from all 11 patients. They were all homosexual men. Eight out of 11 never practised anal sex and the remaining three always used protection. Five of them were living with long term HIV positive partners and were fully aware of safer sex issues. However, all of the five considered unprotected oral sex as a safer activity. Six out of 11 were reported to have recurrent infections of the mouth; two had pharyngeal gonorrhoea, one had herpes simplex stomatitis, two had idiopathic ulcerative stomatitis, and the remaining one had his tongue pierced 10 weeks before his seroconversion. Although oral sex is a lower risk activity for HIV transmission, in compromising situations where the mucosal barrier of the mouth is not intact, it can play a larger part in HIV transmission and can possibly be the sole cause of transmission.

Table 1 Reported incidence of sexually transmitted infections (STI) over past year by respondents

STI	*Diagnosed with an STI in the past 12 months (n = 102)*
Gonorrhoea	36 (35.3)
Chlamydia/NSU	22 (21.6)
Syphilis	4 (3.9)
Herpes (first episode)	20 (19.6)
Warts (first episode)	29 (28.4)
Others	13 (12.7)
Combination of STIs	22 (21.6)
Gonorrhoea + chlamydia/NSU	8 (3.8)

Despite the recent EAGA report,[6] while such uncertainties about the contribution of oral sex to new HIV transmission exist, the delivery of clear safer sex messages to this and other groups will remain difficult to implement.

Our department is now developing a fast track service to enable HIV infected individuals to more easily combine sexual health screening with their HIV outpatient appointment. Efforts by both statutory services and advocacy and support organisations for HIV infected people need to be coordinated to promote these initiatives.

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1 CDSC. AIDS and HIV infection in the United Kingdom: monthly report. *Commun Dis Rep CDR Wkly* 15 February, 2001
2 Dodds JP, Nardone A, Mercey DE, *et al.* Increase in high-risk sexual behaviour among homosexual men, London 1996–8: cross sectional, questionnaire study. *BMJ* 2000;**320**: 1510–1.
3 Grulich A. HIV risk behaviour in gay men: on the rise? *BMJ* 2000;**320**:1487–8.
4 Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet* 1998;**351** (suppl III):5–7.
5 Dillon B, Hecht M, Swanson M, *et al.* Primary HIV infection associated with oral transmission (The options project UCSF). Poster presentation San Francisco January 2000, Seventh conference on retroviruses and opportunistic infection.
6 Department of Health. *Review of the evidence on risk of HIV transmission associated with Oral Sex.* June 2000. Report of a Working Group of the UK Chief Medical Officers' Expert Advisory Group on AIDS. London: DoH.

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BOOK REVIEWS

Sexually Transmitted Diseases, Vaccines, Prevention and Control. Ed Stanberry LR, Bernstein DI. Pp 457; $119.95. New York: Academic Press, 2000. ISBN 0-12-663330-4.

It has become increasingly clear that STIs cannot be controlled simply by diagnosis and treatment of the relevant pathogens alone. This new volume on STI prevention is especially relevant as we struggle to provide access for those already infected with sexually transmitted organisms. My first thought when I looked at this book was influenced by the cover illustration of a herpes simplex virion. It looked like another worthy tome

about vaccine laboratory development spiced up with some phase I and II trial data. However, I am willing to admit that I have been pleasantly surprised by the clinical relevance of much of the book's contents, and that my initial prejudice was unjustified.

The book consists of 18 chapters written by key authors from around the world, such as Lawrence Stanberry, Jonathan Zemilman, and Adrian Mindel who will be well known to readers of this journal. The chapters are divided into three sections dealing with epidemiology, physiology and immunology; non-specific strategies for control (such as behavioural interventions and barrier methods); and pathogens and vaccines. This final section makes up the meat of the book and comprises 11 chapters, which each provide an expert review on vaccine development for specific pathogens including herpes, HPV, hepatitis B, and chlamydia, as well as on gonorrhoea, syphilis and, of course, HIV. While it is inevitable that any book on this rapidly evolving subject will run the risk of becoming out of date, each author has attempted to ensure that relevant previous vaccine strategies and lessons learnt have been included. I felt this was particularly helpful as I believe that the book will be a valuable single reference source, even when the reviews of current vaccine development pass their "sell-by" date. For me, this is the justification in buying this book rather than saving a collection of journal articles.

Highlights from the first two sections of the book included the chapter on vaginal microbicides which incorporated the International Working Group recommendations on development as part of an appendix. The first chapter on global epidemiology of STIs was particularly well written and referenced and includes a concise section on the HIV epidemic. I did however wonder why HHV-8/KSHV was omitted from such a comprehensive review. In a later chapter, I found the 13 or so pages on genital anatomy poorly illustrated and dispensable. I feel that the chapter on the Russian experience and the factors which led to the massive outbreak of syphilis should be compulsory reading for every sexual health clinician and public health specialist. It is too easy to ignore lessons from the past and from other settings.

Stanberry and Bernstein's multiauthor volume provides a timely antidote to those important, but often dry, editions which are divorced from the realities of routine clinical practice. I feel able to recommend this book to the many of us who have endured tedious presentations and never quite got round to actually reading those articles on STI prevention and control which are gathering dust on desks, or worse still put away into filing cabinets "for later reference." And one final plea to the publishers—could they find something a little more human to replace the cover electron micrograph? The whole point of this book is to review ways of ensuring that sexually transmitted pathogens do not gain the upper hand over their human hosts.

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Clinical Risk Management. 2nd ed. Ed Charles Vincent. Pp 583; £47.50. London: BMJ Books, 2001. ISBN 0727913921.

It is a fact of life that people make mistakes. In the NHS the cost of human error runs into billions of pounds a year through lost bed days and the consequences of serious litigation. More importantly, errors distress and harm patients, undermining their confidence in the organisation and their doctors.

The natural approach to discovering any error is to apportion blame, with its associations of moral weakness. But error management that focuses on any one individual's lapses and mistakes will not reduce the incidence of error. In the short term a scapegoat may be convenient, but measures to reduce mistakes need to aim at redesigning systems so that they are acknowledged, detected, intercepted, and mitigated.

Highly reliable organisations, such as nuclear power plants and airlines, have a less than the expected number of accidents because they recognise human frailty. Errors are seen as consequences rather than causes. These organisations concentrate on the conditions under which individuals work and try to build defences averting errors before they happen or reducing their effects. Their motto has to be "Safety is everyone's responsibility."

The focus of any organisation exposed to risk, including the NHS, therefore, needs to be on the constant possibility of failure and how to prevent it. The second edition of *Clinical Risk Management*, edited by Charles Vincent, addresses in detail this problem. It covers the evolution of risk management, its expansion beyond its roots in litigation, and the benefits reaped from the study of safety in high risk organisations. His aim is to highlight the need for clinical risk management to focus on patient safety and quality of care, and not on simplisitic prevention of litigation. It is a practical book full of illustrations of how errors arise, risk, and the good and bad management of their consequences.

The book is divided into four parts. The first, on the principles of risk management, contains a particularly revealing chapter by James Reason, "Understanding adverse events: the human factor." It opens the theme around which the book is constructed, the interrelation between the individual and the organisation. In the second part, "Reducing risks in clinical practice," the authors discuss and illustrate the circumstances which lead to errors and accidents that are inherent in specific "high risk" specialties, such as obstetrics and anaesthetics. Part III, "Conditions of safe practice," discusses the relationship between patient and staff, organisation and environment—for example, in work overload, fatigue, and training. Part IV, "The implementation of risk management" describes the importance of "no blame" culture of reporting incidents, investigating and analysing errors, and of the manner in which adverse events are handled. Included in the chapter are two aspects of error management often overlooked—continuing patient care and support of the staff involved.

This is an important, well written, readable book which all involved in clinical care should keep on their desks, not on the bookshelf.

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NOTICES

International Herpes Alliance and International Herpes Management Forum
The International Herpes Alliance has introduced a website (www.herpesalliance.org) from which can be downloaded patient information leaflets. Its sister organisation the International Herpes Management Forum (website: www.IHMF.org) has launched new guidelines on the management of herpesvirus infections in pregnancy at the 9th International Congress on Infectious Disease (ICID) in Buenos Aires.

Pan-American Health Organization, regional office of the World Health Organization
A catalogue of publications is available online (www.paho.org). The monthly journal of PAHO, the Pan American Journal of Public Health, is also available (subscriptions: pubsvc@tsp.sheridan.com).

6th Seminar of the European Society of Contraception, "Why are teenagers still getting pregnant?", University of Coimbra, Coimbra, Portugal, 8–9 October 2001
Further details: ESC Central Office, OrgaMed, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed@village.uunet.be).

The Theory of Obstetric Medicine for obstetricians, physicians, and GPs, the Royal College of Physicians, Regents Park, London, 9–11 October 2001
Further details: The Symposium Office, Division of Paediatrics, Obstetrics and Gynaecology, IRDB, Imperial College School of Medicine, Hammersmith Campus, Du Cane Road, London W12 0NN (tel: + 44 (0)20 7594 2150; fax. + 44 (0)20 7594 2155; email: sympreg@ic.ac.uk).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 1, Epidemiology of STIs and Bacterial Infections, 22–25 October 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

MSSVD course in STIs and HIV, at the Institute for Materials, 1 Carlton House Terrace, London, Module 4, Sexual Health and Sexuality, 26 October 2001
Further details: Sue Bird, MSSVD STIs and HIV Course Secretariat, PO Box 77, East Horsley, KT24 5YP (tel: 01372 454210).

10th Congress of the European Society for Gynaecological Endoscopy, Lisbon, Portugal, 22–24 November 2001
Further details: Susana Afonso, R Dr Antonio Loureiro Borges, 2 Arquiparque - Miraflores, 1495-131 Algés, Portugal (tel: +351 21 4128 203; fax: +351 21 4120 111; email: martincm@wai.wyeth.com; congress website: www.esge-congress-lisbon.com).